THE DANGEROUS IMPACT OF SUICIDE FUNDING ON OLDER PEOPLE

Expert Testimony presented by Dr. Nancy J. Osgood on March 6, 1997

I am Nancy J. Osgood, Ph. D., and my business address is Gerontology Department, Medical College of Virginia, 301 College Street, Richmond, Virginia 23219. I am a Professor of Gerontology and Sociology at Virginia Commonwealth University--Medical College of Virginia. I have published four books and sixteen articles on suicide, focusing primarily on elderly suicide. Some of my publications have been on ethical issues, assisted suicide, and euthanasia. In the past I have provided expert testimony at hearings on elderly suicide held by the Senate Subcommittee on Aging. I am currently a member of the Board of Directors of the American Association of Suicidology. I am considered an expert on elderly suicide in the United States.

My expert opinion is that, although striking down the legal ban on assisted suicide may benefit a small minority of individuals, who are terminally ill and suffering from unrelenting pain that can not be effectively managed medically, if assisted suicide is legalized, a large number of people, particularly those who are old, disabled, poor, and/or minorities, will suffer. The states have an obligation to prevent suicide and to protect the rights of innocent third parties. My opinion is in agreement with

The New York State Task Force on Life and the Law (1994). The twenty-four members of the New York Task Force concluded that the law should not be changed to permit assisted suicide. Every member of the Task Force concluded that "the potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved" (p. 120). The Task Force further concluded that the dangers of such a change would be the greatest for the elderly, the poor, and the socially disadvantaged. Providing Medicare and/or Medicaid funds to pay for assisted suicide would,. in my opinion, increase the danger to older individuals and poor people and minorities in this country. In this document I will focus on older people as a vulnerable population; however, many of the arguments presented also apply to disabled individuals, poor people, and members of ethnic minorities.

Older Peoole are most "At Risk" for Suicide

Suicide and assisted suicide are issues particularly relevant to older members of our society. Compared to other age groups, those 65 and older are the age group most "at risk" for completing suicide. Currently, in the United States approximately 30,000 annual deaths are recorded as suicides. Among these, more than 6,000 are carried out by older adults, which is one out of every five suicides. Individuals under age twenty-five make up 16% of the U. S. population and account for 16% of all suicides; those 65 and older make up 12% of the population and account for 21% of all suicides (NCHS, 1990). Older adults are also the most likely to be dying. This bill is therefore particularly relevant to older

adults.

The Fallacy of the Terminal Illness Araument

Most proponents of the right to die and death with dignity, as well as those who favor rational suicide and legalized assisted suicide, argue from the perspective of terminal illness and pain and suffering. Psychological autopsy studies conducted in various regions of the United States, Sweden, Australia, and the United Kingdom, however, show that most older people who commit suicide are not terminally ill (Clark, 1991; Brown, et al., 1986; Clark, 1992). Only about 2% to 4% of suicides are suffering from a terminal illness. Many empirical studies of terminally ill individuals have revealed that those who are terminally ill who wish to end their lives are also suffering from depression and have poor relationships or social support (Siegel & Tuckel, 1985; Weisman, 1974; Brown, et al., 1986).

Deoression and Substance Abuse Are Kev Factors in Suicide

Depression is the major factor in most suicides of younger and older individuals. It is estimated that up to 50% of all individuals who commit suicide suffer from major depression, and that this percentage may be even higher in older age groups (Conwell, 1992). In a recent study of suicide among 73 people ages sixty-five and older who died by suicide, Clark (1991) found that only 23% were chronically or severely medically ill and only 14% were terminally ill at the time they chose to end their lives. The majority of those who committed suicide were depressed and/or substance abusers. Large community-based psychological autopsy

studies (Barraclough, et al., 1974; Beskow, 1979; Chynoweth, et al., 1980; Rich, et al., 1986) have confirmed the relationship between major mental disorder and death by suicide. These studies found major affective disorder and/or substance use disorder present in 57% to 86% of all suicides. Clinical studies (Elkin, et al., 1981; Jarvik, et al., 1982; Kramer, 1987) have revealed that older depressed people are more prone than younger depressed people to take their own lives during an acute depressive episode.

Older adults who are depressed and/or abusing alcohol and other drugs are not capable of carefully evaluating all alternatives and making a rational decision to end their lives. Depression creates tunnel vision. For depressed people, present unpleasant states weigh far more heavily than probable future pleasant ones. Depression and substance abuse both result in impaired perception and judgment, memory problems, confusion, and changes in cognition which render an individual incompetent to make a rational choice to end his/her own life.

Conwell and Caine (1991) rightly question the medical profession's ability to distinguish between older people who make a rational decision to terminate their lives and those who are in need of psychiatric care. Conwell's, et al., (1990) psychological autopsy study of 248 persons aged fifty years and over who died by suicide in Monroe County, New York, revealed that 75% of those who committed suicide had seen a physician within a month before their death, but their psychiatric illness was not detected or treated. Earlier clinical studies (Knights & Folstein, 1977; Nielsen &

Williams, 1980) also found that physicians often fail to recognize depression in older adults. Depression and substance abuse are both treatable conditions; and when adequately treated, in most cases the wish to die disappears.

Physical Pain Manaaement

Even for older individuals suffering from physical pain or a terminal illness, there are other solutions besides assisted suicide. Often pain can be effectively controlled without elaborate or expensive outlays. Twycross (1981), Cundiff (1992), Portenoy (1988), and others who work with dying patients and in hospices point out that in many cases, particularly among patients with cancer or who are postoperative, pain is not adequately managed by physicians for several reasons including lack of knowledge about pain medications, lack of communication, a fear of addiction to pain medications, and the belief that most effective pain medications overly sedate patients. Hospice physician David Cundiff (1992), who has had over 25 years of experience working with cancer and AIDS patients, concludes that most terminally ill patients want to live and those who choose to die change their minds when their physical pain managed. Kathleen Foley (1991), a well-known expert on pain control who works at the Memorial Sloan-Kettering Cancer Center, reports that suicidal ideation and suicide requests "commonly . . . dissolve with adequate control of pain and other symptoms" (pp. 289-290). Any system of care and/or payment, which makes assisted suicide an easier option, such as providing funds for the practice, could greatly reduce or even eliminate

discussions of alternative treatment options for older individuals. As Attorney General Vacco of New York put it: "If opponents of assisted suicide prevail in the Supreme Court, we may find ourselves in age of manged care where the most expedient and cost-effective medical procedure will be death instead of treatment" (Quoted by Mark Johnson in Media General News Service).

I believe that this will be even more likely if Medicare and Medicaid pays for assisted suicide.

Ageism and the Vulnerability of Older Adults

Ageism, a term coined by Dr. Robert Butler (1968), former director of the National Institute on Aging (NIA), is defined as "a deep and profound prejudice against the elderly and a systematic stereotyping of and discrimination against people because they are old" (p. 14). Our ageism grows out of our fear of growing old. America has inherited many ideas from the classical Greeks, who viewed aging as an unmitigated misfortune and terrible tragedy. We highly value youth and beauty in this society; and we devalue aging and the aged. Aging is associated with disease, decline, disability, decrepitude, dependence, and death. Ageism is manifested through negative myths and stereotypes about old people. Jokes, cartoons, the media, and other cultural sources portray older people as sexless and senile, cranky and grumpy, non-productive, and an economic burden to be borne by younger members of society.

In a recent book chapter entitled "Rational Suicide Among the Elderly," Derek Humphry (1992) concludes that old age is

"sufficient cause to give up" even without unbearable suffering (p. 125). He views suicide as a "preemptive alternative to growing old" (p. 125). Similarly, Mary Barrington (1969), past president of the London-based Voluntary Euthanasia Society, argues that a disabled older individual in poor health and in need of constant care and attention may feel a burden to the younger person(s) who must provide the care. This situation places the younger caregiver in "bondage"; and Barrington suggests that the older individual may want to (indeed, should) release the younger individual from "bondage." Daniel Callahan (1987) argues for health care rationing on the basis of age. Marshall Kapp (1989) rightly points out that the call by Callahan and others for an explicit public policy of age-based health care rationing fits within the "intergenerational equity" movement. The rallying cry of the movement is that a public dollar spent on older persons is a dollar diverted away from the young. Age-based rationing of health care is, according to Kapp, an official policy of discrimination against older persons. These and other influential individuals are proposing arguments and social policies, which are blatantly ageist.

Robert Kastenbaum (1992), world-renowned expert on death and dying, points out that in our society we associate old age with morbidity and death, and view suicide as a rational choice for older adults. As he suggests, many people feel that the old will die anyway, so suicide just hastens their death. By contrast, the young have a lot of living left to do and suicide is not viewed as

a rational choice for them. Again, ageism rears its ugly head.

Many scholars, physicians, lawyers, and religious leaders are cautioning us to carefully examine current legal and ethical arguments regarding rational suicide and assisted suicide in a broad socio-economic context. We are currently living in an economic climate that emphasizes the high cost of medical technology and the limited availability of health care resources to meet the increasing demands of a growing population. The age group 65+ is the fastest growing segment of the U. S. population, and their increase is accompanied by a phenomenal increase in their health care costs. In the future this growth will continue, and health care costs will rise even more. Many see the growing population of elders, many of whom are ill and/or dependent, as a major threat to their economic security.

Today many older people do not know the doctor who cares for him or her in an acute care hospital. We are currently living in an era of "entrepreneurial medicine," which focuses on productivity, "units of service," and profit making (Caine & Conwell, 1993). Health care rationing, cost containment; and other money saving strategies have assumed major importance in our health care system. Approximately 34 million Americans do not have health insurance. Medical care in America is a privilege, not a right. Many individuals who are old and poor and many members of low income ethnic minorities do not have the means to good medical care, appropriate pain management, or hospice care. In her response to the recent court decision in California lifting the ban

on assisted suicide, Rita Marker, executive director of the Anti-Euthanasia Task Force, has this to say: "If this decision is permitted to stand, it will not be long before the 'right' to death will place every medically vulnerable person in the position of having to justify not 'choosing' this new medical lethal option" (Quoted in USA Today, March 8, 1996).

Older people, living in a suicide-permissive society characterized by ageism, may come to see themselves as a burden on their families or on society and feel it is incumbent upon them to take their own lives or receive assisted suicide. As C. Everett Koop (1985) suggests, others may be pressured into assisted suicide by uncaring or greedy family members. Those who need expensive medical technology to live may be denied help and die. The right to die then becomes not a right at all, but rather an obligation which robs some members of our society of their legal right to live.

In a recent article Wardle (1987) referred to particularly vulnerable groups such as the poor, minorities, the disabled, the aged, and the infirm as the "new illegitimates," and suggested that these people will be at greater risk of having their lives ended pre-maturely by physicians and family members, who encourage them to "choose" rational suicide. According to Gil (1993), devalued populations, such as older adults, may not receive rigorous protection, assessment, and treatment.

As our health care system currently operates, older individuals and others who have limited resources are in a very

vulnerable position, which will be made even worse if the ban against assisted suicide is removed. I agree with Professor Giles Scofield (1995) that --

> The moral issue of our day is not whether to enable or prevent a few individuals' dying in the comfort of their home in the presence of their private physicians. The moral issue of our day is whether to do something about our immoral system of care, in which treatment is dispensed according to a principle best characterized as that of economic apartheid. (p. 491).

Do we really want Medicare and Medicaid funds to be used to support assisted suicide in such a climate?

REFERENCES

Barraclough, B. M., Bunch, J., Nelson, B., & Sainsbury, P. (1974). 100 cases of suicide: Clinical aspects. Br. J Psychiatry, 125, 355-373.

Barrington, M. (1969). Apologia for suicide. In A. B. Downing (Ed.), Euthanasia and the right to die (pp. 152-172). London: Peter Owen.

Beskow, J. (1979). Suicide and mental disorder in Swedish men. Acta Psychiatrica Scandinavica, l, 78-84.

Brown, J. H., Henteleff, P., Barakat, S., & Rowe, C. J. (1986). Is it normal for terminally ill patients to desire death? Am J Psychiatry, 143, 208-211.

Butler, R. N. (1968). Why survive? Being old in America. NY: Harper & Row.

Caine, E. & Conwell, Y. (1993). Self-determined death, the physician, and medical priorities. JAMA, 270, 875-876.

Callahan, D. (1987). Setting limits. NY: Simon and Schuster.

Chynoweth, et al. (1980). Suicide in Brisbane: A retrospective psychosocial study. Austr & New Zealand J Psychiatry, 14, 37.

Clark, D. (1991). Elderly suicide: -Final report 2-3 submitted to the Andrus Foundation, Washington, D. C.

Clark, D. (1992). Rational suicide and people with terminal conditions or disabilities. Issues in Law & Medicine, 4, 147-166.

Conwell, Y., & Caine, E. D. (1991). Rational suicide and the right to die. Nw Ens J Medicine, 325, 1100.

Conwell, Y., et al. (1990). Suicide and cancer in late life. Hospital & Community Psychiatry, 1334, 1337-1338.

Cundiff, D. (1992). Euthanasia is not the answer: A hospice physician's point of view. Tofowa, New Jersey: Humana Press.

Elkin, I., et al. (1989). National Institute of Mental Health treatment of depression collaborative research program: General effectiveness of treatments. Arch Gen Psychiatry, 45, 971-981.

Foley, K. (1991). The relationship of pain and symptom management to patient requests for physician-assisted suicide. J. Pain & Symptom Mgmt., 289-290.

Gil, C. J. (1992). Suicide intervention for people with disabilities: A lesson in inequality. Issues in Law & Medicine, 8, 37-53.

Humphry, D. (1992). Rational suicide among the elderly. In A. A. Leenaars, R. Maris, J. L. McIntosh, & J. Richman (Eds.), Suicide and the older adult. NY: The Guilford Press.

Jarvik, L. F., et al. (1982). Treating geriatric depression: A 26-week interim analysis. J. Am. Geriatrics Society, 30, 713.

Kapp, M. B. (1989). Rationing health care: Will it be necessary? Can it be done without age or disability discrimination? Issues in Law & Medicine, 5, 337-352.

Kastenbaum, R. (1992). Death, suicide, and the older adult.

Suicide & Life-Threatenino Behavior, 22, 1-14.

Knights, E. B., & Folstein, M. D. (1977). Unsuspected emotional and cognitive disturbance in medical patients. Ann Intern Med, 87, 723-724.

Koop, C. E. (1985). The right to live, the right to die, Living Books Edition. Wheaton, IL: Tyndale Health Publishers.

Kramer, B. A. (1987). Electroconvulsive therapy use in geriatric depression. J. Nervous & Mental Disease, 233, 175.

National Center for Health Statistics (1990). Vital statistics of the United States. Washington, D. C.: U. S. Government Printing office.

Nielsen, A. C., III, & Williams, T. A. (1980). Depression in ambulatory medical patients: Prevalence by self-report questionnaires and recognition by nonpsychiatric physicians. Arch Gen Psychiatry, 37, 999-1004.

Portenoy, R. K. (1988, March). The undertreatment of pain. New Physician, 40.

Rich, C. L., Young, D., & Fowler, R. C. (1986). San Diego suicide study, I: Young vs old subjects. Arch Gen Psvchiatrv, 125, 355-373.

Scofield, G. (1995). Exposing some myths about physician-assisted suicide, 18 Seattle U. L. Rev. 473, 481.

Siegel, K., & Tuckel, P. (1984-1985). Rational suicide and the terminally ill cancer patient. OMEGA, 14, 263-269.

The New York State Task Force on Life and The Law, When Death Is Sought: Assisted Suicide and Euthanasia in

the Medical Context (1994), 102.

Twycross, R. G. (1981). Voluntary euthanasia. In S. E. Wallace & A. Esser (Eds.), Suicide and euthanasia: The risht of personhood (pp. 88-89). Knoxville: University of Tennessee Press.

Wardle, L. D. (1987). Sanctioned assisted suicide: "Separate but equal" treatment for the "new illegitimates." Issues in Law & Medicine, 3, 245-265.

Weisman, A. D. (1974). The realization of death. NY: Aronson.